

rhage which leads to the formation of fibrous tissue. He is not inclined to give much credit to the special action of the transplanted slip of muscle. Platt did this operation five years before on a professional acrobat and no dislocations followed the operation, but he had lost so much deltoid that his shoulder-joint musculature was incapable of bearing the full brunt of his gymnastic maneuvers. He entered the army, but Platt believed in a comparatively low category. Threthowan plicated the capsule in 2 cases, in 1 twelve months and in the other fifteen months before, and he had not heard that they had relapsed since.

Pseudomyxoma Peritonei.—BIGGS (*Ann. Surg.*, 1920, lxxi, 619) says that this condition may be described as an inflammation or irritation of the peritoneum, caused by the discharge of the epithelial lining and the contents of a pseudomyxomatous cyst of the ovary or appendix, and resulting in the production of pseudomucin and secondary tumor formation. He thinks that the most tenable theory as to etiology is that of cellular implantation: the epithelial cells lining the cyst, together with the pseudomucinous content of the cyst, being discharged through a rupture of the cyst wall into the peritoneal cavity, the cells there functioning as they did in their original situation. Five cases are reported with the operative and pathological reports in each. He concludes that the condition is much more common than is generally recognized. Caused by cellular implantation it is histologically benign, but may be clinically malignant. If it is considered to be a form of cancer, it must be assumed that pseudomucin inhibits its destructive power. It may originate in the ovary or the intestinal tract; ovarian origin being by far the most frequent. If it is appendiceal in origin, the appendix has been the seat of chronic inflammation. Early invasion of the peritoneum is characterized by a pebbly appearance. In early cases the condition will sometimes be cured, and at any stage it may be inhibited, by operation.

Birth Paralysis.—PLATT (*Jour. Orthop. Surg.*, 1920, ii, 273) reviewed the literature in an effort to arrive at a working hypothesis in dealing with these cases and particularly in our teaching. He has had 23 cases of birth paralysis and in analyzing them he makes four groups. In group 1, in which there were 12 cases, the actual paralysis had recovered and the patients presented the typical subluxation of the shoulder-joint with a fixed internal rotation curvature of the arm. The mechanical disablement was due simply to the torsion and the general underdevelopment of the limb in length and caliber according to the length of time the disability had existed. Group 2, in which there were 6 cases, showed a typical subluxation of the shoulder-joint combined with a residual paralysis affecting the extensors of the wrist, fingers and thumb. The paralysis in the extensor group of muscles recovered under postural treatment in 4 out of 6 cases. In group 3 there were 3 cases which showed varying grades of paralysis. In two the paralysis was observed later to have disappeared completely. In group 4 there were

2 cases which showed exceedingly flail limbs. In one the right arm was profoundly wasted as seen in anterior poliomyelitis and there was the usual downward subluxation of the head of the humerus. Platt performed an arthrodesis in this case. In the second patient, a girl of eighteen, the left arm showed profound atrophy and lack of development in the left upper limb with a flail shoulder and wrist-joint. Platt explored the plexus above the clavicle in this case but found no trace of any lesion in the supraclavicular triangle, the nerve cords being intact but small and on stimulation giving results identical with the clinical findings. He experimented on stillborn full-time fetuses, employed all varieties of violence embodying the maneuver of separation of the shoulder from the head both before exposing the plexus and after. He failed to rupture any cord in any experiment, and on the closest inspection was unable to see any evidence of rupture of the nerve sheath. With excessive force he was unable to produce any dislocation of the shoulder-joint, separation of the epiphysis or in fact any demonstrable lesion of the shoulder-joint capsule. After weighing the clinical evidence he concludes that there is a certain amount of evidence in favor of including under the head of birth palsy two distinct groups of lesions. Under treatment he suggests that before the supraclavicular plexus is exposed in a case of birth palsy there should be in addition to complete paralysis of a muscle group which has persisted for more than twelve months, definite wasting such as is seen in true complete nerve injuries.

Compression Fractures of the Lower End of the Radius.—STEVENS (*Ann. Surg.*, 1920, lxxi, 594) says that fractures of the lower end of the radius (so-called Colles) are always compression fractures, the compressive side breaking first, literally collapsing. The first point of fracture is the point of greatest compression upon the cortical surface of bone because the stress increases both in compression and tension the further away from the neutral axis. It breaks in compression because the compression is much greater than the tension. Green bone reacts to strain like wet timber. It breaks at the lower end of the radius because there are several forces, and the resultant is on the lower end of the radius posteriorly. This is due to direct compression from above, the hammer blow from below, the resistance both to compression and to blow being not in the center of gravity, but eccentric to it and, therefore, increasing the strain. It is also due in part to the velocity of stress and the molecular inertia of material. The compression fractures of the lower end of the radius show the evidence of compression. There is actual loss of substance but no impaction. Breaking up of the impaction (so-called) cannot restore the planes of the articulation, nor does it do so. It might be possible by traction over a long period of time to separate this crushed surface and permit its being filled in by new bone, thus replacing the planes of the articulation, but to do this would be to sacrifice some of our chances of securing a freely movable joint. Early reduction followed by early passive and active motion will return all or nearly all compressive fractures of the radius to useful light occupation within twenty-days. Any retentive apparatus other than a leather wrist strap after ten to twelve days is contra-indicated except in a very rare instance.